

Sarah E. DeYoung* and Ashley K. Farmer

Politicization of COVID-19 and Conspiratorial Beliefs Among Emergency & Public Health Officials

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Abstract: In this research, we identified how political beliefs impact emergency manager's perception of COVID-19 severity and risk. Specifically, we gathered data from people with a broad range of roles in emergency management including healthcare, mitigation, response, fire, rescue, and other areas. We asked respondents their beliefs about the severity of COVID-19, their belief in health conspiracy theories, and the public health measures associated with COVID-19 response. Quantitative results showed political affiliation was a predictor for belief in health conspiracies, as well as beliefs about social distancing as a proper mitigation measure for the spread of COVID-19, and that age and years in emergency management were not significant predictors for beliefs in health conspiracies. Qualitative results included several main themes, including frustration about the politicization of COVID-19 response and mitigation efforts, challenges in PPE (personal protective equipment) procurement, tension between public health and emergency management, misinformation about COVID-19, and lack of leadership at the federal level. These findings fill a gap in the literature regarding how political beliefs shape risk, trust, decision-making, and collaboration within emergency management.

Keywords: COVID-19; emergency managers; health conspiracy beliefs; politicization

1 Introduction

Conspiracy theories about political movements are not new (Goertzel 2010; Uscinski et al. 2020) but the way in which they spread has changed over time with the emergences of social media and rapid exchange of information (Islam et al. 2020; Shahsavari et al. 2020). Conspiracy theories exist throughout the world, and usually

*Corresponding author: Sarah E. DeYoung, Department of Sociology & Criminal Justice, University of Delaware, Newark, USA, E-mail: sedeyoun@udel.edu

Ashley K. Farmer, Illinois State University, Criminal Justice Sciences, Normal, USA, E-mail: akfarme@ilstu.edu

involve key actors and narratives that overlap with some degree of truthfulness, which makes the conspiracy theory more believable by the general public (Wood 2016). Scientific and medical conspiracies can be particularly problematic because they are so persistent and have an impact on buy-in for policies related to scientific findings. For example, increasing frequency of natural hazards are associated with increases in global warming (Alfieri et al. 2017), and yet climate change skeptics occupy a portion of the mainstream narrative (Lahsen 2013). Medical conspiracy theories in the United States have centered around the idea that the government has a nefarious role in vaccinations and public health measures such as water fluoridation (Oliver and Wood 2014).

While these policies may be driven by science skepticism rather than conspiracy theories per se, this demonstrates how broad public beliefs and even beliefs of key officials can influence language, implementation, and outcomes of federal and state legislation. This becomes challenging in disasters. One well-known conspiracy theory in disaster historical research is the idea that 9–11 was an “inside job” (Stempel et al. 2007; Wood and Douglas 2013). Misinformation, rumors, and conspiracies also spread disease outbreak scenarios, such as during the Ebola outbreaks of 2016 (Earnshaw et al. 2019).

Such misinformation surrounded the initial phases of the COVID-19 pandemic. The term ‘plandemic’ emerged, which insinuated that COVID was created or manufactured, and allegations circulated that 5G technology played a role in spreading the virus (Gruzd and Mai 2020). Many of these conspiracies were shared online. In March 2020, Twitter users started taking photos and videos of hospitals to prove that COVID was a hoax, with the premise being that if hospitals were not crowded, then COVID must not be as serious as public health officials alleged (Gruzd and Mai 2020).

Underlying the skepticism and conspiracy theories is an inherent distrust of government. In order to understand the response to the COVID-19 pandemic, it is essential to understand policy and politics (Greer et al. 2020). While the United States is a democracy and therefore has better flow of public information compared to authoritarian regimes, this also means less ability taking forceful action (Greer et al. 2020). For instance, orders for stay-at-home mandates were met with resistance in cities across the United States. Also, of importance are social and economic policies that center gaining public compliance by making compliance easier, as well as state capacity to deliver services and enforce restrictions (Greer et al. 2020).

Part of this skepticism transfers to the death toll of COVID-19 as well. There is a risk that mortality rates will be attributed to policy and politics, without understanding the limitations on data about COVID-19 morbidity and mortality (Greer et al. 2020). This happens after disasters as well, as there is rarely a precise death toll (Bourque et al. 2007). The infection and mortality rates publicized are meant to give an estimate as to the spread of the virus and indicates severity of the problem. Even still, mortality rates

due to COVID-19 are questioned, with some asserting that the numbers are inflated. This further contributes to conspiracies about the realities of COVID-19.

Broader political, social, and other movements can influence individual health behavior (Minkler 1999). Moreover, political ideologies can influence health behaviors and decision-making during stressful events (Olatunji 2018). Additionally, political ideologies and beliefs influence organizational decision-making (Nilson 1995) and leadership (Song et al. 2018). Specific beliefs in conspiracy theories regarding COVID-19 can influence actions for protective behavior, such as social distancing (Allington et al. 2020; Banai et al. 2020; Bierwaczzonek et al. 2020). There is a scarcity of research of how political ideologies are associated with decision-making and roles in emergency management. Studies in this area more broadly discuss coordination and emergency management (Bankoff and Hilhorst 2009) and similarities in beliefs within emergency management (Song et al. 2018). Nilson (1995) describes theoretical implications for political polarities as left and right having an influence on the ways on which disasters are framed and understood. For example, Nilson (1995) describes how social control versus social mobilization framing can change the disaster interpretation. Specifically, people who align more with the social control model may be more susceptible to believe breakdowns in social order and other “disaster myths” such as looting (Nilson, p 13). This is still relevant in 2020, as President Trump indicated that he wanted to “downplay the virus, because he did not want to cause a panic” (Thomas and Gittleston 2020).

In recent research on COVID-19, general population respondents who believe in CT's are less likely to wear masks and engage in other protective behaviors (Allington et al. 2020) and even in healthcare workers (Chen et al. 2020). Additionally, research suggests that social contexts such as political beliefs can influence the uptake of belief in CT's despite information from health and medical experts (Rothmund et al. 2020). Other factors that can influence the rapid spread of CT's include information sharing and gathering, particularly in social media (Jiang et al. 2020). Research suggests that political beliefs among the public may influence beliefs in CT's about COVID-19 (Miller 2020). Additionally, there is research on how first responders make decisions in crisis situations (Olatunji 2018), or organizational leaders in crisis (e.g. Van Wart and Kapucu 2011). However, there is a scarcity research on the ways in which political beliefs and beliefs in conspiracy theories impact decision-making in emergency and disaster management. Decisions that emergency managers make are important because they are key coordinators working with public health, medical, and other officials to manage the pandemic. For this research, we focus on beliefs about COVID-19 conspiracy theories in emergency management officials.

This study analyzed survey response from people with a broad range of roles in emergency management, including healthcare, mitigation, response, fire, rescue, and other roles. Specifically, we focus on the following research questions: (1) What is the relationship between political beliefs and belief in COVID-19 conspiracy theories?

(2) What aspects of communication or coordination contribute to politicization of COVID-19? (3) What additional challenges have emergency management officials identified in responding to COVID-19?

2 Methods

Institutional Review Board approval was obtained for this research at (university of delaware for peer review). In the spring and summer of 2020, we gathered data using a systematic social media recruitment approach (redacted citation for blind review) (Farmer and DeYoung 2019). Specifically, we posted a link and brief recruitment script in social media groups that focus on emergency management issues, crisis management, extreme weather, disaster management, and emergency response. This included multiple closed emergency management Facebook groups such as Emergency Management Issues (over 8000 members) and Emergency Management Nexus (approximately 2900 members), and the Emergency Management Higher Education Community (approximately 2900 members) and Twitter, using the hashtag #EMGTwitter for recruitment of respondents.

2.1 Quantitative Analyses

The Qualtrics survey included 22 questions about demographics, risk perception of local hazards, beliefs about COVID-19 risks, political ideologies, and perceptions about crisis management. The average time spent on the survey was 12 min. The COVID-19 conspiracy beliefs scale was adapted by a subscale from Brotherton et al. (2013). The questions included items such as “The government withholds a lot of information about diseases and their treatments from the public.” And “Viruses and/or diseases have been deliberately disseminated to infect certain populations” (level of agreement on a Likert scale). We also included questions that asked respondents if they believed that the COVID-19 death tolls were under-reported, over-reported, or accurate. Political beliefs were coded as 1 = very liberal and 5 = very conservative.

2.2 Qualitative Analyses

The researchers independently coded the open-ended themes to the questions about challenges, success, changes in planning for natural hazards due to COVID-19, and “Is there anything else you would like to share about your perceptions and experience in managing COVID-19”. Specifically, in round one of coding, one researcher identified

major themes and created a code book to share with another researcher. For round two of coding, another researcher reviewed all respondent data and coded each response using the codebook and proposed new codes that were not included in the original coding manual. Finally, for round three of coding, the original researcher reviewed and consolidated coded themes that the second researcher created. Each respondent quote could contain more than one core theme, but we checked for agreement of the prominent/first theme within the researcher's independent codes. We compared agreement for the initial codes and then did a second round of coding

Table 1: Qualitative coding examples.

Question	Quote	Coding theme(s)
Biggest organization challenge	Multiple threads in the management structure not communicating with each other leading to poor communication.	Communication; leadership
Biggest organization challenge	Reliable and sustainable approach to PPE	Supplies
Biggest organization success	Coordinated efforts by healthcare agencies	Logistics
Biggest organization success	We got in front of the local issues, anticipated needs, and created working teams. We did not wait for state and federal resources to start our planning	Logistics
How has COVID changed planning for disasters?	The realization of requiring a new way to shelter people in the event of a Hurricane while still dealing with COVID-19. Also, the need for a stockpile of needed PPE to accommodate COVID during a Hurricane event.	Logistics
How has COVID changed planning for disasters?	We are thinking differently about congregate sheltering and we would be more likely to use virtual EOC if we need to activate for a hurricane.	Logistics
Anything else to share	While critique of the federal response will likely be harsh, I feel like it's fair and stems from the inexperience of the members on the White House Task force.	Consequences; politicization
Anything else to share	As emergency managers, we're supposed to help prepare the nation and our communities for all hazards to our best ability. It's disappointing to see that preparations for a pandemic weren't as resilient as maybe some thought they were.	Preparedness

to confirm the full list of possible codes (Belotto 2018). See Table 1 for the code book and examples of coding for the themes.

3 Results

3.1 Demographics

While approximately 247 people responded to the survey, we filtered out responses that took less than 2 min to engage with the survey and respondents that were missing responses to most items. After filtering these responses, there were 179 people who completed the survey. The mean age of respondents was 42.88. Respondents included people from Canada ($n = 2$), Australia ($n = 1$), Pakistan ($n = 3$), Japan ($n = 1$), South Africa ($n = 1$), Slovenia ($n = 1$), Taiwan ($n = 1$), and North Macedonia ($n = 1$). However, majority of respondents were located within the United States ($n = 153$) ($n = 16$ missing or other). Responses from the United States came from all regions—the Midwest, Southwest, East coast, West coast, and Central states. Respondents were diverse in terms of expertise. They included county, state, and federal workers, as well as across multiple types of roles and areas including fire response, communication, public health, fisheries and wildlife, logistics, law enforcement, mitigation and planning, social work, and research.

3.2 Regression Analyses

The Chronbach's alpha of health conspiracy measure for this study was $\alpha = 0.85$. Means and standard deviations are presented in Table 2. Before conducting regression analyses, we conducted bivariate regressions (Table 3) to test for the relationship

Table 2: Descriptives.

	Descriptive statistics		
	Mean	Std. deviation	<i>N</i>
Sum health conspiracy	19.97	8.109	159
Respondent age	42.88	12.595	159
Political	2.99	1.212	159
CVID overreported	2.11	1.268	159
Phys dist. necessary	4.58	0.837	159

Table 3: Bivariate correlations.

Correlations										
	political	covid_overreport	covid_underreport	covid_accurate	phys_dist_nec	phys_dist_notnec	Sum health conspiracy			
political	Pearson correlation	1	0.383 ^a	-0.296 ^a	-0.013	-0.337 ^a	0.297 ^a	0.448 ^a		
	Sig. (2-tailed)		0.000	0.000	0.873	0.000	0.000	0.000		
	N	163	161	160	161	161	161	163		
covid_overreport	Pearson correlation	0.383 ^a	1	-0.542 ^a	-0.001	-0.447 ^a	0.501 ^a	0.402 ^a		
	Sig. (2-tailed)	0.000	^b	0.000	0.992	0.000	0.000	0.000		
	N	161	162	161	162	162	162	162		
covid_underreported	Pearson correlation	-0.296 ^a	-0.542 ^a	1	-0.347 ^a	0.311 ^a	-0.225 ^a	-0.199 ^b		
	Sig. (2-tailed)	0.000	0.000	^b	0.000	0.000	0.004	0.012		
	N	160	161	161	161	161	161	161		
covid_accurate	Pearson correlation	-0.013	-0.001	-0.347 ^a	1	0.062	-0.035	-0.229 ^a		
	Sig. (2-tailed)	0.873	0.992	0.000	^b	0.434	0.654	0.003		
	N	161	162	161	162	162	162	162		
phys_dist_nec	Pearson correlation	-0.337 ^a	-0.447 ^a	0.311 ^a	0.062	1	-0.532 ^a	-0.376 ^a		
	Sig. (2-tailed)	0.000	0.000	0.000	0.434	^b	0.000	0.000		
	N	161	162	161	162	162	162	162		
phys_dist_not nec	Pearson correlation	0.297 ^a	0.501 ^a	-0.225 ^a	-0.035	-0.532 ^a	1	0.427 ^a		
	Sig. (2-tailed)	0.000	0.000	0.004	0.654	0.000	^b	0.000		
	N	161	162	161	162	162	162	162		

Table 3: (continued)

		Correlations							
		political	covid_overreport	covid_underreport	covid_accurate	phys_dist_nec	phys_dist_notnec	Sum health conspiracy	
sum health conspiracy	Pearson correlation	0.448 ^a	0.402 ^a	-0.199 ^b	-0.229 ^a	-0.376 ^a	0.427 ^a	1	
	Sig. (2-tailed)	0.000	0.000	0.012	0.003	0.000	0.000	^b	
	N	163	162	161	162	162	162	246	

^aCorrelation is significant at the 0.01 level (2-tailed). ^bCorrelation is significant at the 0.05 level (2-tailed).

between the COVID conspiracy belief scale, respondents' political beliefs, age, and the survey item of "Physical distancing measures are necessary to slow the spread of COVID-19" (measured as a Likert agreement). Examination of these correlations led to the decision to include age, political beliefs, COVID-death toll as over-reported, and physical distance as necessary as key predictors in the regression. The outcome/dependent variable in the regression was the sum score of health conspiracy belief (COVID-19 adapted version).

We examined outliers using Mahalanobis Distance and checked for collinearity by examining Tolerance and VIF scores. Two cases were deemed outliers upon examining Mahalanobis Distance, but we maintained those two cases for analyses because they also provided rich open-ended responses. A significant model emerged: $F(4,154) = 16.183$, $p < 0.001$. The model explains 29 % of the variance in health conspiracy belief (adjusted $R_2 = 0.2780$). Specifically, the more politically conservative score was associated with a higher score on health conspiracy beliefs. Additionally, the belief in COVID death tolls as overreported ($p = 0.007$) and the belief in physical distancing ($p = 0.026$) also contributed to the model, but with a negative relationship for belief in physical distancing (Table 3). In other words, the more conservative scores were associated with less belief in the need for physical distancing as a mitigation measure for managing COVID-19 and a higher belief in death tolls being over-reported.

3.3 Qualitative Results

We identified 14 themes from the question that asked respondents, "What has been the biggest challenge for your organization or community during the COVID-19 response?" Those themes were communication, supplies, information or misinformation, compliance, logistics, politics, leadership, economy, expectations, impact, coordination, expertise, decision-making/risk, and uncertainty.

We identified 8 themes from the question of, "Is there anything else you would like to share about your perceptions and experience in managing COVID-19?" These codes were preparedness, expertise, politicization, disorder, consequences, geographic, coordination, and leadership. We also asked, "How has COVID-19 changed planning in your group or organization for the upcoming hurricane and or wildfire season? And "What has been the biggest success for your organization or community during the COVID-19 response?" We present the findings here with examples from the most common themes across all open-ended data: logistics, communication, expertise, and coordination challenges".

3.4 Logistics & Supplies

Respondents indicated procurement of testing and Personal Protective Equipment (PPE) as a major concern and source of on-going frustration. There was no reliable or sustainable approach to getting PPE for responders. As a respondent noted, with testing being scaled up, this meant a lack of PPE for the healthcare system. In response to major challenges, one respondent indicated:

Protective equipment acquisition, local fire departments deciding to cease responding with EMS as first responders, which was their usual practice prior to COVID. This results in insufficient manpower and often critical delays in providing care.

Another respondent indicated that the entire system seems to fail in terms of procuring and managing PPE. The respondents indicated that this was a critical failure in the COVID response. In response to describing challenges, another respondent indicated:

Responding to an emergency with equipment that doesn't meet a regulatory standard. As this response continues, determining regulatory needs and standards. We've always exceeded the minimum quality for PPE. Now we have to figure out what that is to purchase equipment that we can continue to use.

Some aspects of logistics centered on personnel and organizational changes. Specifically, the format and modality for meetings and procedures were perceived as a source of confusion, stress, and lack of organization efficiency. One respondent indicated:

All of our plans must be reconsidered to incorporate physical distancing. This will have cascading effects on resources (i.e. more buses needed for hurricane evacuations to allow people to sit further apart). In addition, exercises and in-person meetings that would normally be held to support planning are either being made virtual or are being delayed.

The impact of new COVID-related measures was far-reaching. As the respondent above works in disaster response, their plans for the impending hurricane season required restructuring. Respondents also expressed exasperation over continuous organizational changes and expectations:

The ever-changing response protocols and the constant ask of what is going to happen next. Being asked to predict things that cannot be predicted, like how many cases do you think we will have next week or the week after, etc.

These responses also overlapped with communication challenges. For example, protocols rapidly changing had an impact on organizational flow and decision-

making, and these changes caused more confusion if there was a lack of communication about new protocols that did not reach all members of the organization at the same time.

3.5 Communication & Misinformation

Due to new and rapidly changing information, communication also emerged as an issue among those in emergency management. Specifically, lack of coordination among and between agencies, including government entities, led to misinformation and ultimately confusion among those working in emergency response roles. This was especially true for public announcements made by those in the political sphere, without regard for implementation related to those announcements. As one respondent noted:

It's a shit show in the sense of building the plane while we fly it. Politicians announce policy before it has operational and logistical backing, leaving [emergency managers] to scramble or take the blame for failures. I often find out about new policy or operational considerations from press conferences.

Many of the communication challenges seemed to vary at different levels of government. For example, this respondent indicated:

We found a real disconnect between state organizations and operations and the Counties. Often, we would have to wait until the Governors Press Briefing to find out what was going to happen in the next 24–48 hours. We got very little guidance from our state representatives that was not micromanaged by the Governors Orders. It would have been a better operation if the state agencies were allowed to manage the event within their own ranks without constant changes in the middle of operations.

Communication was even more difficult because much of it became virtual. As one respondent mentioned in working with a large state emergency operations center, which works to bring people together to collaborate on challenges and identify solutions:

Much of this collaboration involves reading people, body language, strengths, weaknesses, decisiveness and indecisiveness, etc. This becomes incredibly challenging in a “virtual” environment.

While communication between levels of government became problematic, especially from the federal level, there were indications that local-level responses were going better. As this respondent noted:

The lack of coordinated information from the federal government was problematic and disorienting. On the other hand, [the] state and county we are in did a great job communicating and coordinating with us with the information known and resources available.

Misinformation was also another aspect of communication that respondents indicated as prevalent in the pandemic response. A respondent mentioned that it was difficult to fight “fake news” and conspiracy theory groups. This of course made the job more difficult and added to problems with communication. As another emergency response worker responded:

This crisis seems more political than anything. Nobody seems to listen to or care about what the experts (emergency management, health officials, etc.) Have to say, and many of our problems can stem from incompetent leaders.

This reflects the frustration the many of the respondents expressed over combatting misinformation about COVID-19 throughout the pandemic. False health information was rampant online and even in national press conferences (BBC 2020). Political leaders at the state level disagreed with county level leaders about mask mandates, business closings, and a myriad of other issues that spilled into debates and communication among officials responding to the pandemic.

3.6 Expertise & Leadership

Because of the misinformation and conspiracy theories, the credibility of emergency response personnel, and especially those in the public health sector, was publicly questioned. As one respondent mentioned, “The public is confused by national leaders contradicting public health experts.” Those with expertise and experience to contribute to the public health response to COVID-19 were not necessarily in positions of leadership. A respondent working in Higher Ed emergency response had similar concerns:

Leadership must listen to the experts in their fields. Emergency management was partially pushed to the side and student health (medical doctors) were completely pushed to the side when it came to make final decisions about the University’s response to COVID.

Respondents indicated that leaders continued to discount the expertise of those in emergency management, whose experience could have been beneficial to the planning and response to COVID-19:

Even as late as mid-February, we had some in leadership positions saying that even if COVID-19 became an “issue”, it wouldn’t be an Emergency Management problem, as it was in the Health Department’s lane and not ours. Some of us tried to explain that that assumption wasn’t

necessarily accurate, to little of no avail. I wish I had spoken louder that we needed to lean into this, sooner.

In the following comments, the respondents echoed the concerns about whether emergency management or public health was better equipped and experienced in managing large-scale events:

Healthcare has been exposed for how poorly prepared they are and how little investment and priority is given to proper preparedness. Also, Public Health has little experience with managing large disasters. They have been unwilling to let Emergency Management take over the coordination of the event while allowing Public health to maintain command control. As such the response at large has been poorly handled.

Public health is considered to have a lead role in managing COVID-19, however, they are responsible for the health orders and community health. They do not have experience in the other emergency management aspects, yet emergency managers have not been allowed to engage in a leadership focus. Emergency managers are needed to lead for recovery and the social elements to this incident beyond the public health implications.

The local health department is managing the incident. However, there is a clear disconnect between the health department and emergency management.

These comments indicate that jurisdictional issues and delineation of response areas were important and that respondents felt that there was a lack of clarity these issues. They also indicated that the social and community aspects of response required expertise that spanned beyond public health. Public health officials may be trained in communication and outreach, but many respondents seemed to emphasize that the lack of input from emergency management was problematic. In the next section we expand upon this issue by describing challenges related to coordination.

3.6.1 Coordination Challenges

There has been ongoing frustration, much of that expressed by respondents in this study, with many factors through planning, preparedness, and response to COVID-19. Part of this frustration was that so many agencies and organizations had to work together in new ways yet were not recognized or acknowledged for the difficulties in response. As one respondent noted about this frustration as it relates to challenges:

Still getting the work done even if the federal administration is trying to take all the credit and tools away.

However, there were also comments that indicated that there were some organizational strategies that led to perceptions of success. For example, one respondent indicated:

Providing safe shelter to hundreds of [sic] people experiencing homelessness, being some of the earliest to supply free testing to anyone who wants a test and feeding the most vulnerable members of our community.

There were also successes mentioned in how city governments and departments worked together, especially with new videoconferencing to make things move more efficiently. One of the most illuminating statements that summarized these data was as follows:

The system we have been taught did not [sic] work. When disasters happen, you deal with them locally. When you run out of resources, you call the state – when they run out, the feds come. Someone decided to shut that pipeline down. Wrong, just wrong.

Similarly, another respondent stated, “While critique of the federal response will likely be harsh, I feel like it’s fair and stems from the inexperience of the members on the White House Task Force.” These challenges in the response to COVID-19 highlight some of the ways that the United States failed to prepare for a global pandemic, leaving many in emergency response roles to fend for themselves with their local governments.

3.7 Political Aspects

Through news coverage and political pundits and leaders, COVID-19 has been politicized. Much of this politicization relates to decisions from state and local politicians on whether to announce and/or enforce restrictions with businesses and other operations. As one respondent indicated:

The political difficulty of reopening because the state has a set of rules that they can’t explain. Our county commissioners desire getting open in a safe manner to save our economy. This has created problems with if a business opens it may lose its state license to operate, etc. so leaves a big gap in knowing what anyone should do. This should be based on science not politics.

There has been disagreement about prioritizing the economy during the pandemic, especially as positivity rates across the United States continued to rise, and rural areas started to experience an influx with an increase in cases. As the respondent above noted, political points of view have skewed opinions. This has happened to such an extent that expertise of scientists is not trusted.

3.8 General stress

Finally, it is also important to point out the likelihood of burnout by emergency officials, especially for those who lost colleagues, family members, and peers to COVID-19. For example, this respondent describes their overall level of trauma associated with COVID-19 response:

I am a retired FDNY Paramedic working part time in another state, have experienced the death of numerous partners and colleagues I have worked with due to COVID, even more that have had lengthy time on ventilators and survived. It takes an emotional strength to continue .../... There has been a tremendous failure by both the federal and state leaders to provide accurate, correct and trustworthy leadership on a consistent basis, made twice as hard by uneducated public forcing wrong politically based decisions to be made by the government. Yet we first responders and healthcare professionals are the pawns in the middle, taking considerable personal risk because of these poor decisions.

Stress is also occurring because of the uncertainty associated with COVID, especially with not having a clear end in sight:

Hurricanes have a light at the end of the tunnel, i.e. the roads are open, electric is at 95% restoration. There are benchmarks in place as a result of a number of landfalling hurricanes over the last 5 years. We have progress markers. None of that applies here. This is a slog – we're 80 days into an activation and the only sign of progress is we're beating models we didn't have a lot of faith in to begin with.

The on-going pandemic stress could be particularly problematic during hurricane and fire seasons in the United States. The staff, volunteers, and other respondents in the disaster system can experience long-term trauma associated with event exposure (Brooks et al. 2019), and it is still unclear how the impacts of on-going pandemic response might compound with stress from other hazard response operations and occupational stress.

4 Discussion

There were two core aspects to these findings: (1) quantitative results indicate that political beliefs significantly impacted susceptibility in COVID-19 conspiracy theories among the respondents and were also associated with beliefs about the proper measures to manage the pandemic, and (2) qualitative data suggest that the overall response to COVID-19 unfolded as a myriad of failures, frustrations, and challenges. The regression results that show a relationship between political beliefs and beliefs of COVID-19 response measures suggest that individual beliefs may impact decision-

making at the organizational level, especially if the beliefs change decision-making by people with more access to power and operational changes.

While there were some indicators and responses that reflect organizational lessons learned (such as learning strategies for improving communications through virtual channels or new strategies for reaching extremely vulnerable population members such as homeless individuals), the entire system of emergency management as it is designed to work did not work during the pandemic. One key theme was that there was tension and conflict about “whose lane” the pandemic is in—in other words, public health and emergency management were/are at times viewed at odds with one another. This lack of cooperation or inter-agency conflict about “who should be in charge” can slow down response time and key operations for logistics (Liu, Xu, and John et al. 2021). This may have been exacerbated in some ways by the ways in which local government conflicted with state ordinates, or vice versa. For example, in 2020 the governor of the state of Georgia (Brian Kemp) threatened litigation when the mayor of Atlanta (Keisha Lance Bottoms) moved to enact measures to prevent the spread of COVID-19, such as a mask mandate (Romo 2020).

Another implication from this response and throughout these data is that “someone” decided to shut down the pipeline, and so the failure in managing COVID-19 was beyond the explanation that the event was too catastrophic or that the actors were incompetent. Rather, this statement and overall data suggest that the failure to manage COVID-19 may have been intentional. In other words, in the United States, the executive leadership/Trump administration placed non-experts on the Pandemic Task Force, failed to integrate emergency management operations with public health expertise, and engaged in false messaging about the virus at nearly every stage of the pandemic. The skepticism over the PPE supplies seems to be linked with several different root issues—ranging from actual supply chain failures (Cao et al. 2020) to ideas and beliefs about conspiracies (Gu et al. 2021).

Response decisions and public press conferences by political leaders had repercussions for those working in all levels of emergency management. The politicization of COVID-19 and the spread of misinformation that transpired at the start of the pandemic led to changes in protective behaviors among the public and resistance against public health advice, which in turn made response phases more difficult. Emergency management officials are susceptible to this as well, as political ideologies can influence decision-making (Nilson 1995; Olatunji 2018). Our research did not include measures of actual decision-making (such as “Did you make decisions about PPE or social distancing requirements in your organization or community”). However, these outcomes may be useful as measures in future research because then this could allow for analyses of the ways in which conspiratorial thinking influences decision-making. This may be difficult to measure because of social desirability in response. However, there may be more subtle impacts that conspiratorial thinking

can have—such as outcomes in leadership style, organizational culture, or impacts on staffing and other resource decisions.

5 Conclusions

Our results suggest that there is a relationship between political beliefs and conspiratorial thinking. Specifically, respondents in this study who were more politically conservative had higher scores of believing in health conspiracies as measured through the composite conspiracy health scale. Additionally, political beliefs were also associated with beliefs about the death tolls as an impact of the COVID-19 pandemic. There is a scarcity of research on political beliefs in emergency management. However, because disasters are shaped by political systems and policies (e.g. Gerber 2007), it is important to continue to examine the ways in which beliefs among emergency managers overlap with decision-making, health beliefs, leadership, communication, and other critical factors of crisis response.

Conflict of interest statement: The authors declare no conflict of interest for this research and paper.

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